| 8. RESTORATIONS AND TREATMENTS (Completed during service) | 9. SUBSEQUENT DISEASES AND ABNORMALITIES |
|---|---|

A B C D E F G H I J

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

A B C D E F G H I J

RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

| REMARKS | REMARKS |
|---|---|

## 10. SERVICES PROVIDED

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry) | CLASS |
|---|---|---|
| | | |

| PATIENT'S NAME: | SSN: |
|---|---|

SF 603A (SIDE 2)

## 8. RESTORATIONS AND TREATMENTS (Completed during service)

A B C D E F G H I J

RIGHT | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 | LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

REMARKS

## 9. SUBSEQUENT DISEASES AND ABNORMALITIES

A B C D E F G H I J

RIGHT | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 | LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

REMARKS

## 10. SERVICES PROVIDED

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry) | CLASS |
|------|------------------------------------------------------------------------------|-------|
| | **PERIODIC ORAL EVALUATION** | |
| | BP ___/___                            PSR | |
| | BWX ___ PAX ___ PANX ___ | |
| | SOFT TISSUE WNL: Yes / No | |
| | CARIES RISK: Low  Mod  High | |
| | TOBACCO: No  Smoke  Chew  Both | |

PATIENT'S NAME:                                    SSN:

SF 603A (SIDE 2)

| **HEALTH RECORD** | **DENTAL – Continuation** |
|---|---|

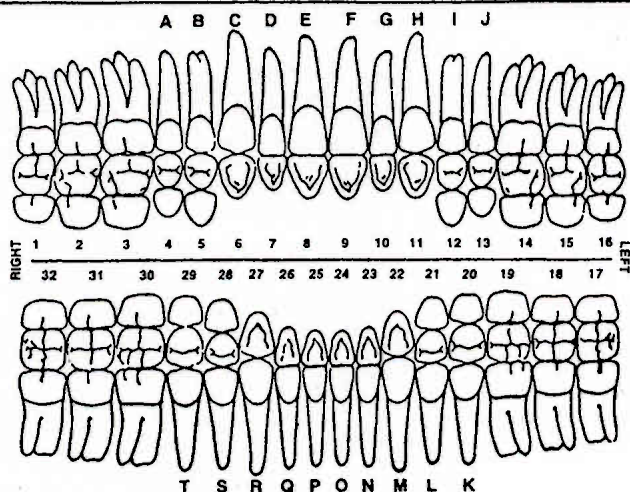## SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE          PAGE:

| 8. RESTORATIONS AND TREATMENTS *(Completed during service)* | 9. SUBSEQUENT DISEASES AND ABNORMALITIES |
|---|---|

A B C D E F G H I J

RIGHT   1   2   3   4   5   6   7   8   9   10   11   12   13   14   15   16   LEFT
        32  31  30  29  28  27  26  25  24  23  22  21  20  19  18  17

T S R Q P O N M L K

A B C D E F G H I J

RIGHT   1   2   3   4   5   6   7   8   9   10   11   12   13   14   15   16   LEFT
        32  31  30  29  28  27  26  25  24  23  22  21  20  19  18  17

T S R Q P O N M L K

REMARKS                                    REMARKS

## 10. SERVICES PROVIDED
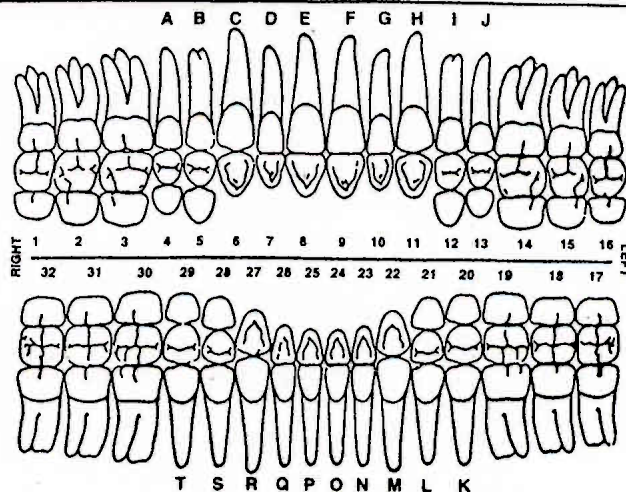
| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY *(Sign each entry)* | CLASS |
|---|---|---|
| | **PERIODIC ORAL EVALUATION** | |
| | BP ___/___                          PSR | |
| | BWX ___ PAX ___ PANX ___ | |
| | SOFT TISSUE WNL: Yes / No | |
| | CARIES RISK:  Low  Mod  High | |
| | TOBACCO: No  Smoke  Chew  Both | |

| PATIENT'S IDENTIFICATION *(Use this Space for Mechanical Imprint)* | PATIENT'S NAME (Last, First, Middle Initial) | | | SEX |
|---|---|---|---|---|
| | DATE OF BIRTH | RELATIONSHIP TO SPONSOR | COMPONENT/STATUS | DEPART/SERVICE |
| | SPONSOR'S NAME | | | RANK/GRADE |
| | SSN OR IDENTIFICATION NO. | | ORGANIZATION | |